FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036632

Facility Name: COUNTRYSIDE HEALTHCARE CENTER

Address: 1635 EAST 154TH STREET (Number) DOLTON (City) 60419 (Zip Code)

County: COOK

Telephone Number: (847) 329-1555 **Fax #** (847) 329-9555

IDPA ID Number: 36-3730831

Date of Initial License for Current Owners: 11/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,260	1,260	8
9	SNF/PED					9
10	ICF	59,922	34		59,956	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,922	34	1,260	61,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.13%

D. How many bed-hold days during this year were paid by the Department?
892 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,173

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	177,873	17,508	12,103	207,484		207,484		207,484			1
2	Food Purchase		243,117		243,117		243,117	(263)	242,854			2
3	Housekeeping	156,948	29,345		186,293		186,293		186,293			3
4	Laundry	58,505	13,853	1,257	73,615		73,615		73,615			4
5	Heat and Other Utilities			143,628	143,628		143,628	63	143,691			5
6	Maintenance	66,189	25,302	23,191	114,682		114,682	8,195	122,877			6
7	Other (specify):*			11,767	11,767		11,767	49	11,816			7
8	**TOTAL General Services**	459,515	329,125	191,946	980,586		980,586	8,044	988,630			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	1,442,245	64,666	59,740	1,566,651		1,566,651	(11,508)	1,555,143			10
10a	Therapy	61,378	1,289	46,374	109,041		109,041	981	110,022			10a
11	Activities	81,803	15,724	3,200	100,727		100,727		100,727			11
12	Social Services	329,054			329,054		329,054		329,054			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,914,480	81,679	113,814	2,109,973		2,109,973	(10,527)	2,099,446			16
	C. General Administration											
17	Administrative	114,073		444,000	558,073		558,073	(323,340)	234,733			17
18	Directors Fees											18
19	Professional Services			264,883	264,883		264,883	(194,679)	70,204			19
20	Dues, Fees, Subscriptions & Promotions			41,621	41,621		41,621	(4,257)	37,364			20
21	Clerical & General Office Expenses	177,761	21,419	302,064	501,244		501,244	(212,886)	288,358			21
22	Employee Benefits & Payroll Taxes			364,154	364,154		364,154		364,154			22
23	Inservice Training & Education							1,665	1,665			23
24	Travel and Seminar			1,579	1,579		1,579	323	1,902			24
25	Other Admin. Staff Transportation			1,416	1,416		1,416	3,692	5,108			25
26	Insurance-Prop.Liab.Malpractice			257,643	257,643		257,643	1,874	259,517			26
27	Other (specify):*							72,498	72,498			27
28	**TOTAL General Administration**	291,834	21,419	1,677,360	1,990,613		1,990,613	(655,110)	1,335,503			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,665,829	432,223	1,983,120	5,081,172		5,081,172	(657,593)	4,423,579			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: COUNTRYSIDE HEALTHCARE CENTER #0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,133	
	REPAIRS & MAINTENANCE		1,970	
			0	12,103
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,257	
			0	1,257
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		43,765	
	ELECTRICITY		65,538	
	WATER		32,781	
	CABLE TV - LOBBY		1,544	
			0	143,628
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,261	
	PAINTING & DECORATING		1,263	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,520	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,140	
	FIRE SERVICE		3,007	
			0	
			0	
			0	23,191
7	**OTHER**			
	SCAVENGER		11,767	
	SECURITY SERVICE		0	11,767
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,500	4,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,800	
	PHARMACY CONSULTANT	XVIII B 39-2	3,540	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	50,000	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		4,400	
			0	59,740
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,350	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		1,363	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES	XVIII B 43-2	29,261	46,374
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,200	
			0	3,200
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER #0036632 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	444,000	444,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	29,107	
	ADMINISTRATIVE CONSULTANTS	XIX C	186,000	
	PROFESSIONAL FEES	XIX C	49,776	
			0	264,883
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,664	
	EMPLOYEE WANT ADS	XIX F	30,611	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	90	
	LICENSES & PERMITS	XIX F	1,892	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	864	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	41,621
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		6,879	
	OUTSIDE CLERICAL SERVICES		119,748	
	PENALTIES / OVERDRAFT CHARGES	VI 18	32,977	
	HOME OFFICE EXPENSE		123,112	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,348	
	MESSENGER SERVICE		0	
			0	302,064

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	199,746	
	UNEMPLOYMENT COMPENSATION	XIX D	94,014	
	WORKERS COMPENSATION INSURANCI	XIX D	54,825	
	HOSPITALIZATION INSURANCE	XIX D	7,368	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,702	
	EMPLOYEE PHYSICAL EXAMS	XIX D	395	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,104	
	CHICAGO HEAD TAX	XIX D	0	364,154
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,579	
	TRAVEL	XIX G	0	
			0	
			0	1,579
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,416	1,416
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		257,643	257,643
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,983,120

COUNTRYSIDE HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	243,117	PATIENT MEALS	183648
LESS SALES TAX	(263)	ADD EMPLOYEE MEALS	0
NET FOOD	242,854	TOTAL MEALS/YEAR	183648
TOTAL PATIENT CENSUS	61,216	NET FOOD	242854
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	183648
TOTAL PATIENT MEALS	183648	COST PER MEAL	1.32
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER #0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			40,156	40,156		40,156	184,489	224,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,627	30,627		30,627	487,957	518,584			32
33	Real Estate Taxes			513,423	513,423		513,423		513,423			33
34	Rent-Facility & Grounds			831,660	831,660		831,660	(831,660)				34
35	Rent-Equipment & Vehicles			49,432	49,432		49,432	(21,227)	28,205			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,465,298	1,465,298		1,465,298	(180,441)	1,284,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,958	27,356	83,314		83,314	(2,774)	80,540			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,858	107,858		107,858		107,858			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		55,958	135,214	191,172		191,172	(2,774)	188,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,665,829	488,181	3,583,632	6,737,642		6,737,642	(840,808)	5,896,834			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,086	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(263)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(32,977)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(694)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(7,664)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(864)	20		28
29	Other-Attach Schedule SEE PAGE 5 A	(39,669)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,545)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(760,263)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (760,263)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (840,808)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
COUNTRYSIDE HEALTHCARE CENTER
ID# 0036632
Report Period Beginning: 01/01/2005
Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING	$ (39,669)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(39,669)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER **#** 0036632 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(263)	0	0	0	0	0	0	0	0	0	0	(263)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	63	0	0	0	0	0	0	0	0	63	5
6	Maintenance	0	0	8,195	0	0	0	0	0	0	0	0	8,195	6
7	Other (specify):*	0	0	49	0	0	0	0	0	0	0	0	49	7
8	**TOTAL General Services**	(263)	0	8,307	0	0	0	0	0	0	0	0	8,044	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(11,508)	0	0	0	0	0	0	0	0	(11,508)	10
10a	Therapy	0	(2,702)	3,683	0	0	0	0	0	0	0	0	981	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(2,702)	(7,825)	0	0	0	0	0	0	0	0	(10,527)	16
	C. General Administration													
17	Administrative	0	0	(323,340)	0	0	0	0	0	0	0	0	(323,340)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(694)	0	(193,985)	0	0	0	0	0	0	0	0	(194,679)	19
20	Fees, Subscriptions & Promotions	(9,028)	0	4,771	0	0	0	0	0	0	0	0	(4,257)	20
21	Clerical & General Office Expenses	(72,646)	0	(140,240)	0	0	0	0	0	0	0	0	(212,886)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,665	0	0	0	0	0	0	0	0	1,665	23
24	Travel and Seminar	0	0	323	0	0	0	0	0	0	0	0	323	24
25	Other Admin. Staff Transportation	0	0	3,692	0	0	0	0	0	0	0	0	3,692	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,874	0	0	0	0	0	0	0	1,874	26
27	Other (specify):*	0	0	0	72,498	0	0	0	0	0	0	0	72,498	27
28	**TOTAL General Administration**	(82,368)	0	(647,114)	74,372	0	0	0	0	0	0	0	(655,110)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(82,631)	(2,702)	(646,632)	74,372	0	0	0	0	0	0	0	(657,593)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,086	169,240	0	13,163	0	0	0	0	0	0	0	184,489	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	426,103	0	61,854	0	0	0	0	0	0	0	487,957	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(831,660)	0	0	0	0	0	0	0	0	0	(831,660)	34
35	Rent-Equipment & Vehicles	0	(29,856)	0	8,629	0	0	0	0	0	0	0	(21,227)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,086	(266,173)	0	83,646	0	0	0	0	0	0	0	(180,441)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(2,774)	0	0	0	0	0	0	0	0	0	(2,774)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	(2,774)	0	0	0	0	0	0	0	0	0	(2,774)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(80,545)	(271,649)	(646,632)	158,018	0	0	0	0	0	0	0	(840,808)	45

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE				COUNTRYSIDE		
				H/C LLC	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 831,660	COUNTRYSIDE HEALTHCARE CENTER, LLC		$	$ (831,660)	1
2	V	30	SL DEPRECIATION		" "		165,369	165,369	2
3	V	32	INTEREST		" "		424,010	424,010	3
4	V								4
5	V								5
6	V								6
7	V	10A	THERAPY SERVICES	46,374	CAREPLUS REHABILITATIVE SERVICES		43,672	(2,702)	7
8	V	39	ANCILLARY THERAPY	27,356	" "		24,582	(2,774)	8
9	V	35	EQUIPMENT RENT	29,856	" "			(29,856)	9
10	V	30	SL DEPRESIATION		" "		3,871	3,871	10
11	V	32	INTEREST		" "		2,093	2,093	11
12	V								12
13	V								13
14	Total			$ 935,246			$ 663,597	$ * (271,649)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	HOME OFFICE EXPENSE	$ 123,112	CAREPLUS MGMT. INC.		$	$ (123,112)	15
16	V	17	MANAGEMENT FEES	444,000	" "			(444,000)	16
17	V	19	ADMIN. CONSULT FEES	186,000	" "			(186,000)	17
18	V	19	DATA PROCESS FEES	14,400	" "			(14,400)	18
19	V	21	CLERICAL FEES	118,200	" "			(118,200)	19
20	V	10	PSYCHIATRIC CONS. FEE	50,000	" "			(50,000)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	5	UTILITIES		" "		63	63	25
26	V	6	MAINT & REPAIRS		" "		3,050	3,050	26
27	V	6	MAINTENANCE SALARIES		" "		5,145	5,145	27
28	V	7	SECURITY		" "		49	49	28
29	V	10	NURSING SALARIES		" "		38,492	38,492	29
30	V	10A	THERAPY SALARIES		" "		3,683	3,683	30
31	V	17	ADMIN SALARIES		" "		120,660	120,660	31
32	V	19	PROFESSIONAL FEES		" "		6,415	6,415	32
33	V	20	ADVERTISING		" "		4,771	4,771	33
34	V	21	TOTAL OFFICE		" "		37,723	37,723	34
35	V	21	CLERICAL SALARIES		" "		63,349	63,349	35
36	V	23	SEMINAR		" "		1,665	1,665	36
37	V	24	TRAVEL		" "		323	323	37
38	V	25	TRANSPORTATION		" "		3,692	3,692	38
39	Total			$ 935,712			$ 289,080	$ * (646,632)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	INSURANCE	$	CAREPLUS MGMT. INC.		$ 1,874	$ 1,874	15
16	V	27	EMPLOYEE BENEFITS		" "		72,498	72,498	16
17	V	30	DEPRECIATION (SL)		" "		13,163	13,163	17
18	V	32	INTEREST		" "		61,854	61,854	18
19	V	35	EQUIPMENT RENT		" "		8,629	8,629	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 158,018	$ * 158,018	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGT ALLOCATIONS:								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.	36.17	SEE ATTACHED	6.6		SALARY	22,109	17-7	2
3			FINANCE		SCHEDULE						3
4	JACOB BAKST	DIR OPERATIONS	ADMINISTRAT.	21.57		6.6		SALARY	22,109	17-7	4
5			CONSULTING								5
6	ROSLYN INDICH	CLERICAL	CLERICAL	2.54		6.6		SALARY	1,819	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 46,037		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 8320 SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	UTILITIES	CENSUS DAYS	553,765	13	574		61,216	63	2
3	6	MAINT & REPAIRS	CENSUS DAYS	553,765	13	27,588		61,216	3,050	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	553,765	13	46,540	46,540	61,216	5,145	4
5	7	SECURITY	CENSUS DAYS	553,765	13	444		61,216	49	5
6	10	NURSING SALARIES	CENSUS DAYS	553,765	13	348,203	348,203	61,216	38,492	6
7	10A	THERAPY SALARIES	CENSUS DAYS	553,765	13	33,317	33,317	61,216	3,683	7
8	17	ADMIN SALARIES	CENSUS DAYS	553,765	13	1,091,504	1,091,504	61,216	120,660	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	553,765	13	58,031		61,216	6,415	9
10	20	ADVERTISING	CENSUS DAYS	553,765	13	43,163		61,216	4,771	10
11	21	TOTAL OFFICE	CENSUS DAYS	553,765	13	341,243		61,216	37,723	11
12	21	CLERICAL SALARIES	CENSUS DAYS	553,765	13	573,059	573,059	61,216	63,349	12
13	23	SEMINAR	CENSUS DAYS	553,765	13	15,061		61,216	1,665	13
14	24	TRAVEL	CENSUS DAYS	553,765	13	2,923		61,216	323	14
15	25	TRANSPORTATION	CENSUS DAYS	553,765	13	33,401		61,216	3,692	15
16	26	INSURANCE	CENSUS DAYS	553,765	13	16,951		61,216	1,874	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	553,765	13	655,825		61,216	72,498	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	553,765	13	119,076		61,216	13,163	18
19	32	INTEREST	CENSUS DAYS	553,765	13	559,538		61,216	61,854	19
20	35	EQUIPMENT RENT	CENSUS DAYS	553,765	13	78,057		61,216	8,629	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,044,498	$ 2,092,623		$ 447,098	25

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: COUNTRYSIDE HEALTHCARE CENTER, LLC						$	$			$	1
2	CORUS BANK		X	MORTGAGE	$85,159.76	05/98	4,343,980	2,277,613		0.0939	242,187	2
3	COUNTRYSIDE PLAZA		X	JR MORTGAGE	$17,307.38	05/98	1,978,877	1,765,525	05/08	0.0950	169,708	3
4	CIB BANK		X	CAPITAL IMPROVEMENTS	$6,078.93	01/04	540,000	142,225	01/09	PRIME+	12,115	4
5	CAREPLUS MANAGEMENT ALLOCATION:LOC,ETC										61,854	5
	Working Capital											
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND	04/95	1,015,000	771,706		PRIME+	26,744	6
7	A.I. CREDIT CORP.		X	INSURANCE FINANCING							3,883	7
8	CAREPLUS REHAB ALLOCATION:EQUIPMENT LOANS										2,093	8
9	TOTAL Facility Related				$108,546.07		$ 7,877,857	$ 4,957,069			$ 518,584	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,877,857	$ 4,957,069			$ 518,584	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	448,531	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	478,584	2
3. Under or (over) accrual (line 2 minus line 1).	$	30,053	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	483,370	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	513,423	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	408,867	8
	2001	458,382	9
	2002	434,119	10
	2003	444,090	11
	2004	478,584	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0036632

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-13-100-001-0000	NURSING HOME	$ 478,584.17	$ 478,584.17
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 478,584.17	$ 478,584.17

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,547 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	132,928	1998	$ 392,750	1
2					2
3	TOTALS	132,928		$ 392,750	3

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	1997		1998		$ 5,408,525	$ 138,675	39	$ 138,675	$	$ 1,057,532	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	24,648	782	31.5	782		11,617	9
10	LEASEHOLD IMPROVEMENTS			1992	28,172	894	31.5	894		12,115	10
11	LEASEHOLD IMPROVEMENTS			1993	11,940	337	31.5	337		4,569	11
12	LEASEHOLD IMPROVEMENTS			1994	4,878	125	39	125		1,419	12
13	TILE / ROOF VENTS			1995	16,191	416	39	416		4,373	13
14	WALL / WATER PANEL			1995	4,199	107	39	107		1,108	14
15	LANDSCAPING/PARKING LOT REPAIRS			1995	13,614	908	15	908		9,533	15
16	ROOF REPAIRS			1996	13,369	342	39	342		3,299	16
17	SINK			1996	683	18	39	18		171	17
18	ROOF-TOP A/C UNIT			1996	5,100	131	39	131		1,206	18
19	WINDOWS			1996	1,080	28	39	28		255	19
20	WINDOWS			1997	14,040	360	39	360		3,073	20
21	WALK-IN FREEZER			1997	3,196	82	39	82		687	21
22	WINDOWS			1998	8,370	214	39	214		1,646	22
23	FLOORING / TILE / CARPETING			1998	3,396	87	39	87		666	23
24	CEILING TILES			1998	2,213	57	39	57		411	24
25	ROOF REPAIRS / ROOFTOP A/C			1999	33,838	868	39	868		5,533	25
26	ROOF REPAIRS			2000	13,505	346	39	346		2,033	26
27	INSTALLATION CORNICES & SHEERS			2000	3,280	119	27.5	119		660	27
28	DRAPERY PANELS			2000	2,170	190	20	109	(81)	654	28
29	CARPETING OFFICES			2001	1,814	209	20	91	(118)	455	29
30	INSTALLED ROOF TOP UNIT			2001	6,992	254	27.5	254		1,027	30
31	LOBBY, NURSES STATION, HALLWAY-FLOORING,CEILING			2003	100,619	3,659	27.5	3,659		9,910	31
32	REMOVAL AND REINSTALLATION OF CUBICLE TRACKS			2003	4,501	864	20	225	(639)	675	32
33	REPLACE FIRE ALARM SYSTEM			2003	5,204	189	27.5	189		433	33
34	NEW DURO-LAST ROOFING SYSTEM			2003	28,100	1,022	27.5	1,022		2,087	34
35	PAINTING			2004	4,100	1,312	20	205	(1,107)	410	35
36	BATHROOMS AND OFFICE REMODELING			2004	43,350	1,576	27.5	1,576		1,642	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPLACED FRONT DOOR	2004	$ 2,164	$ 79	27.5	$ 79	$	$ 135	37
38	REPLACEMENT OF DECK PANELS	2005	74,108	2,583	27.5	2,583		2,583	38
39	INSTALLED DELAYED EGRESS	2005	6,875	219	27.5	219		219	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54	RELATED PARTY ALLOCATION:								54
55	COUNTRYSIDE HEALTHCARE CENTER LLC								55
56	ROOF	2001	255,225	9,123	39	9,123		39,154	56
57									57
58	CAREPLUS MGMT								58
59	BUILDING-TAG-18 PROPERTIES	2004	69,195	1,774	39	1,774			59
60	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	27,184	1,047	39	1,047			60
61									61
62	CAREPLUS REHAB								62
63	ROOF VENTILATOR	2003	1,967	50	39	50			63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,247,805	$ 169,046		$ 167,101	$ (1,945)	$ 1,181,290	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 284,561	$ 15,360	$ 24,206	$ 8,846		$ 173,281	71
72	Current Year Purchases	32,095	6,419	1,604	(4,815)		1,604	72
73	Fully Depreciated Assets	48,601					48,601	73
74	RELATED PARTY SL DEPRECIATION		31,734	31,734				74
75	TOTALS	$ 365,257	$ 53,513	$ 57,544	$ 4,031		$ 223,486	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,005,812	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 222,559	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,645	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,086	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,404,776	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 43,213 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 DODGE RAM	$ 682.00	$ 6,219	17
18					18
19					19
20					20
21	TOTAL		$ 682.00	$ 6,219	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 24,561	$		$ 24,561	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			2,795			2,795	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				55,918		55,918	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MEDICAL SUPPLIES	39-2					40		40	13
14	TOTAL			$		$ 27,356	$ 55,958		$ 83,314	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER **#** 0036632 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (40,546)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,635)	2,756,868		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,580		6
7	Other Prepaid Expenses	88,391		7
8	Accounts Receivable (owners or related parties)	107,966		8
9	Other(specify): Real Estate Tax Escrow	9,969		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,067,228	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	485,708		15
16	Equipment, at Historical Cost	365,257		16
17	Accumulated Depreciation (book methods)	(414,273)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 436,692	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,503,920	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 585,154	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,775		28
29	Short-Term Notes Payable	771,706		29
30	Accrued Salaries Payable	174,980		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,920		31
32	Accrued Real Estate Taxes(Sch.IX-B)	483,370		32
33	Accrued Interest Payable	2,555		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,081,460	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,081,460	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,422,460	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,503,920	$	48

***(See instructions.)**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,324,015	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(81,164)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,242,851	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	179,609	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 179,609	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,422,460	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,917,251	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,917,251	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,917,251	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	980,586	31
32	Health Care	2,109,973	32
33	General Administration	1,990,613	33
	B. Capital Expense		
34	Ownership	1,465,298	34
	C. Ancillary Expense		
35	Special Cost Centers	83,314	35
36	Provider Participation Fee	107,858	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,737,642	40
41	**Income before Income Taxes (line 30 minus line 40)****	179,609	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 179,609	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,891	2,159	$ 72,361	$ 33.52	1
2	Assistant Director of Nursing	1,966	2,126	62,502	29.40	2
3	Registered Nurses	5,316	5,439	134,897	24.80	3
4	Licensed Practical Nurses	28,461	29,491	592,634	20.10	4
5	CNAs & Orderlies	60,340	63,873	557,477	8.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,894	6,550	61,378	9.37	8
9	Activity Director	1,291	1,398	21,379	15.29	9
10	Activity Assistants	7,446	8,018	60,424	7.54	10
11	Social Service Workers	19,169	20,286	329,054	16.22	11
12	Dietician					12
13	Food Service Supervisor	1,822	1,987	31,691	15.95	13
14	Head Cook	4,870	5,341	49,482	9.26	14
15	Cook Helpers/Assistants	13,071	13,685	96,700	7.07	15
16	Dishwashers					16
17	Maintenance Workers	5,935	6,193	66,189	10.69	17
18	Housekeepers	21,172	22,094	156,948	7.10	18
19	Laundry	7,855	8,302	58,505	7.05	19
20	Administrator	1,952	2,239	73,875	32.99	20
21	Assistant Administrator	1,880	2,060	40,198	19.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,004	8,662	138,092	15.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,121	2,290	22,374	9.77	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	937	1,137	39,669	34.89	33
34	TOTAL (lines 1 - 33)	200,393	213,330	$ 2,665,829 *	$ 12.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,133	1-3	35
36	Medical Director	O	4,500	9-3	36
37	Medical Records Consultant	N	1,800	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,540	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,200	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PSYCHIATRIC	E	50,000	10-3	46
47		S			47
48					48
49	TOTAL (lines 35 - 48)		$ 87,573		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CALLIE GRAHAM	ADMIN	0	$ 48,758
STEVE KIEKAMP	ADMIN	0	6,648
MARIANNE SPRATT	ADMIN	0	18,469
KIERRONIS MCDOWELL	ASST ADMIN	0	26,933
ELIMELECH RAY	ASST ADMIN	0	13,265
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,073

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 444,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 444,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		264,883
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 264,883

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 54,825
Unemployment Compensation Insurance		94,014
FICA Taxes		199,746
Employee Health Insurance		7,368
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		6,702
EMPLOYEE PHYSICAL EXAMS		395
PENSION/PROFIT SHARING PLANS		1,104
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 364,154

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,611
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,528
TRUST/FRANCHISE/CONTRIB/ETC	500
LICENSES & PERMITS	1,892
DUES & SUBSCRIPTIONS	90
MGMT CO ALLOCATION	4,771
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,664)
Yellow page advertising	(864)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,364

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	323
Seminar Expense	
	1,579
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,902

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11							N/A						
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **307** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **107,858**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees